Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST LLC
PO BOX 890008
HOUSTON TX 77289

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box
Box Number 05

MFDR Tracking Number
M4-12-2942-01

MFDR Date Received
MAY 21, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In the first preauthorization letter granted to HealthTrust, the Travelers authorization unit stated this notice in its actual preauthorization letter: carrier has accepted as compensable only the following injury: *Acute left shoulder/upper arm sprain strain. The carrier disputes that the compensable injury extends to or includes any other body part or diagnosis, including but not limited to bone, cartilage or structural integrity of the skeleton other than as expressly accepted. Carrier disputes that the injury extends to arthritis or other degenerative are denied as not being the result of the compensable accident or the direct/result thereof. Right should is disputed. The carrier denies that the compensable extends to or includes left shoulder acromioclavicular arthrosis, persistent tear of the rotator cuff, impingement syndrome as these conditions were present on 2-9-207 MRI. Dispute mental health issues, anxiety, depression, psych disorders, mental stress.* As once can see, two of the three codes utilized by HealthTrust are indicated as being accepted by the carrier. A Benefit Review Conference was held on February 17, 2011 to medicate solution of the disputed issues of whether or not a tear of the supraspinatus and infraspinatus was included as part of the compensable injury. No resolution was reached so a CCH was held on March 24, 2011, and the following decision was reached. The diagnoses of the tears were deemed not casually related to the compensable injury sustained on May 16.2010. However< [sic] it was confirmed that the compensable injury of the left shoulder was accepted and it was even granted a 3% impairment rating to the left shoulder."

Amount in Dispute: $16,300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**THIS REQUEST FOR MEDICAL FEE DIPSUTE RESOLUTION SHOULD BE DISMISSED UNDER RULE 133.307(e)(3)(H) AS THE CARRIER HAS RAISED AN EXTENT OF INJURY ISSUE REGARDING THIS DIAGNOSIS WHICH HASD BEEN RESOLVED IN THE CARRIER'S FAVOR AT THE CONTESTED CASE HEARING. THEREFORE, THE TREATED DIAGNOSES ARE NOT PART OF THE COMPENSABLE INJURY.**

FURTHERMORE, THIS REQUEST FOR MEDICAL FEE DISPUTE RESOLUTION IS UNTIMELY FILED FOR DATE OF SERVICE 01-25-2011, AND NO REIMBRUSEMENT [sic] **SHOULD BE ORDER FOR THIS SERVICE PURSUANT TO RULE 133.307(c)…**

The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for psychological evaluations and a chronic pain management program. The Provider performed and billed for CPT codes 96102 and 97799-CP referencing primary ICD-9 diagnosis code 840.4. The Carrier reviewed the billing and denied reimbursement

as the services at issue were unrelated to the compensable injury per the Contested Case Hearing Decision regarding extent of injury, which found the compensable injury did not extend to include the extensive tearing and arthrosis in the Claimant's shoulder. Although the CCH Decision does not document it, the Carrier accepted a compensable injury limited to a sprain/strain of the shoulder…

The Provider alleges entitlement to reimbursement for the disputed services based on the argument that the psychological and chronic pain services were billed for the compensable shoulder sprain/strain injury of 05-16-2010 (and not the long-standing should tear pathology dating years earlier) under CPT Code 840.4, and therefore were provided for the accepted compensable injury of shoulder sprain/strain, and not for the diagnosed rotator cuff tear. This argument is disingenuous at best. A review of the medical documentation for the claim clearly documents long-standing treatment of the disputed shoulder tears rather than the accepted shoulder sprain/strain injury. The AMA ICD-9 codebook documents that ICD-9 code 840.4 is the code for a rotator cuff tear per the diagnosis index. This is emphasized in the description of the base ICD-9 840 code, which documents the code is to be used for 'injury to the ligaments when one or more is stretched/*torn*'.

As the Contested Case Hearing Decision found that the tears wand arthrosis of the shoulder were not related to the compensable injury, the Carrier would not e liable for reimbursement for services to treat those unrelated conditions… The RME doctor, Dr. Xeller, clearly documents the sprain/strain had resolved, and that a pain management program would not be related to the compensable injury. As the services were not related to the compensable shoulder sprain/strain, the Carrier is not liable for reimbursement."

Response Submitted by: Travelers Indemnity Co., 1401 S. Mopac Expressway, Ste. A320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 24, 2001 through December 20, 2011	CPT Codes 96102 and 97799-CP	$16,300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Codes §133.305 and 133.3077 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the procedures for Workers' Compensation Specific Services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W12 – Extent Issue, PLN 11 attached.
   - 033B, 214 – WC claim adjudicated as non-compensable. This payer not liable for clm or svc/treatment. This claim is being denied for multiple reasons. A TWCC-62 stating the specific reasons will be sent to you under separate cover.
   - W1 – Workers Compensation state F/S adj. reimbursement based on max allowable fee for this proc. Based on medical F/S, or if one is not specified, UCR for the Zip Code area.
   - 16 – Claim/service lacks information which is needed for adjudication.
   - Z001 – For explanation of a non-payment by the adjuster, please cont the adjuster on file.
   - W12 – Extent of Injury. No finally adjudicated.
   - 45 – Charge exceeds fee sch/max allowable or contract/legislated fee arrangement. You are not an authorized Travelers HCN provider. At this time your services are being denied by the claim adjuster.
   - W2 - Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.

Issues

1. Are all dates of services eligible for review?
2. Has the extent of injury issue been resolved?
3. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code (c)(1)(B)(i) A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (B) a request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability. The Contested Case Hearing decision was issued March 28, 2011; date of service January 25, 2011 was not submitted to the Division until May 21, 2012; therefore, date of service is untimely and is not eligible for review.
2. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Codes §§413.031 and 408.021." The services in dispute were denied, in part, due to an unresolved extent of injury issue. The disputed issue involved whether the compensable injury extends to and includes tears of the supraspinatus and infrasptinatus tendons. A Contested Case Hearing was held on March 24, 2011; it was the decision of the Hearing Officer that the claimant's injury sustained on may 216, 2010 does not extend to and include tears of the supraspinatus and infraspinatus tendon. The Division concludes that the extent of injury issue is resolved.

3. Review of the documentation submitted indicates that the provider billed for its services in box 21 of the CMS1500 under diagnoses codes 1. 840.4 (Rotator Cuff (capsule)), 2. 840.9 (Unspecified site of shoulder and upper arm) and 3. 719.41 Pain in joint, shoulder region). The treatments in dispute were rendered for an injury which the Contested Case Hearing of March 24, 2011, discussed above. The requestor rendered health care to this injured employee for the non-compensable tears of the supraspinatus and infraspinatus tendons; therefore, no reimbursement can be recommended for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 14, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.